



Texas Department of Insurance

Division of Workers' Compensation

Medical Fee Dispute Resolution, MS-48

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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

SOUTH TEXAS HEALTH SYSTEM
3255 W PIONEER PKWY
ARLINGTON TX 76013-4620

Respondent Name

Ullico Casualty Co

Carrier's Austin Representative Box

Box Number 20

MFDR Tracking Number

M4-11-2106-01

MFDR Date Received

February 25, 2011

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The correct allowable due is \$3,998.72, minus their payment of \$2,428.71 there is still an outstanding balance of \$1,570.01."

Amount in Dispute: \$1,570.01

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: No response

Response Required by: Ullico Casualty Co

SUMMARY OF FINDINGS

Date(s) of Service	Disputed Services	Amount In Dispute	Amount Due
July 30, 2010 and August 2, 2010	Outpatient Hospital Services	\$1,570.01	\$9.62

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.403, titled *Hospital Facility Fee Guideline – Outpatient*, sets out the reimbursement guidelines for facility services provided in an outpatient acute care hospital.
3. 28 Texas Administrative Code §134.203, titled *Medical Fee Guideline for Professional Services*, sets out the reimbursement guidelines for professional medical services.
4. The services in dispute were reduced/denied by the respondent with the following reason codes:

Explanation of benefits dated November 26, 2010

- 176 – Modifier 27 / TC represents the technical component of service performed
- 222 – Charge exceeds Fee Schedule allowance

- 248 – A bilateral surgical procedure was performed
- 785 – Items and/or services are packaged into APC rate. Therefore there is no separate APC payment.
- 788 – Significant procedure. Multiple procedure reduction applies.
- 881 – This item is an integral part of an emergency room visit or surgical procedure and is therefore included in the reimbursement for the facility/APC rate.
- I59 – 59 – Charges are adjusted based on multiple surgery or concurrent anesthesia rule.
- I97 – 97 – Payment is included in the allowance for another service/procedure.
- IW1 – W1 – Workers Compensation State Fee Schedule Adjustment

Explanation of benefits dated January 13, 2011

- 18 – Duplicate claim/service.
- 193 – Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.
- W4 – No additional reimbursement allowed after review of appeal/reconsideration.

Issues

1. Are the disputed services subject to a contractual agreement between the parties to this dispute?
2. What is the applicable rule for determining reimbursement for the disputed services?
3. What is the recommended payment amount for the services in dispute?
4. Is the requestor entitled to reimbursement?

Findings

1. Review of the submitted documentation finds no information to support that the disputed services are subject to a contractual agreement between the parties to this dispute.
2. This dispute relates to facility services performed in an outpatient hospital setting with reimbursement subject to the provisions of 28 Texas Administrative Code §134.403, which requires that the reimbursement calculation used for establishing the maximum allowable reimbursement (MAR) shall be the Medicare facility specific amount, including outlier payment amounts, determined by applying the most recently adopted and effective Medicare Outpatient Prospective Payment System (OPPS) reimbursement formula and factors as published annually in the Federal Register with the application of minimal modifications as set forth in the rule. Per §134.403(f)(1), the sum of the Medicare facility specific reimbursement amount and any applicable outlier payment amount shall be multiplied by 200 percent, unless a facility or surgical implant provider requests separate reimbursement of implantables. Review of the submitted documentation finds that separate reimbursement for implantables was not requested.
3. Under the Medicare Outpatient Prospective Payment System (OPPS), each billed service is assigned an Ambulatory Payment Classification (APC) based on the procedure code used, the supporting documentation and the other services that appear on the bill. A payment rate is established for each APC. Depending on the services provided, hospitals may be paid for more than one APC per encounter. Payment for ancillary and supportive items and services, including services that are billed without procedure codes, is packaged into payment for the primary service. A full list of APCs is published quarterly in the OPPS final rules which are publicly available through the Centers for Medicare and Medicaid Services (CMS) website. Reimbursement for the disputed services is calculated as follows:
 - Procedure code 36415, date of service July 30, 2010, has a status indicator of A, which denotes services paid under a fee schedule or payment system other than OPPS. Per 28 Texas Administrative Code §134.403(h), for outpatient services for which Medicare reimburses using fee schedules other than OPPS, reimbursement is made using the applicable Division fee guideline in effect for that service on the date the service was provided. Facility payment for the technical component of this service is calculated according to the Medical Fee Guideline for Professional Services, §134.203(e)(1). The fee listed for this code in the Medicare Clinical Fee Schedule is \$3.00. 125% of this amount is \$3.75. The recommended payment is \$3.75.
 - Procedure code 80053, date of service July 30, 2010, has a status indicator of A, which denotes services paid under a fee schedule or payment system other than OPPS. Per 28 Texas Administrative Code §134.403(h), for outpatient services for which Medicare reimburses using fee schedules other than OPPS, reimbursement is made using the applicable Division fee guideline in effect for that service on the date the service was provided. Facility payment for the technical component of this service is calculated according to the Medical Fee Guideline for Professional Services, §134.203(e)(1). The fee listed for this code in the Medicare Clinical Fee Schedule is \$15.14. 125% of this amount is \$18.93. The recommended payment is \$18.93.

- Procedure code 85025, date of service July 30, 2010, has a status indicator of A, which denotes services paid under a fee schedule or payment system other than OPPS. Per 28 Texas Administrative Code §134.403(h), for outpatient services for which Medicare reimburses using fee schedules other than OPPS, reimbursement is made using the applicable Division fee guideline in effect for that service on the date the service was provided. Facility payment for the technical component of this service is calculated according to the Medical Fee Guideline for Professional Services, §134.203(e)(1). The fee listed for this code in the Medicare Clinical Fee Schedule is \$11.14. 125% of this amount is \$13.93. The recommended payment is \$13.93.
- Procedure code 81003, date of service July 30, 2010, has a status indicator of A, which denotes services paid under a fee schedule or payment system other than OPPS. Per 28 Texas Administrative Code §134.403(h), for outpatient services for which Medicare reimburses using fee schedules other than OPPS, reimbursement is made using the applicable Division fee guideline in effect for that service on the date the service was provided. Facility payment for the technical component of this service is calculated according to the Medical Fee Guideline for Professional Services, §134.203(e)(1). The fee listed for this code in the Medicare Clinical Fee Schedule is \$3.22. 125% of this amount is \$4.03. The recommended payment is \$4.03.
- Procedure code 71020, date of service July 30, 2010, has a status indicator of X, which denotes ancillary services paid under OPPS with separate APC payment. These services are classified under APC 0260, which, per OPPS Addendum A, has a payment rate of \$44.90. This amount multiplied by 60% yields an unadjusted labor-related amount of \$26.94. This amount multiplied by the annual wage index for this facility of 0.8883 yields an adjusted labor-related amount of \$23.93. The non-labor related portion is 40% of the APC rate or \$17.96. The sum of the labor and non-labor related amounts is \$41.89. The cost of these services does not exceed the annual fixed-dollar threshold of \$2,175. The outlier payment amount is \$0. The total APC payment for this line is \$41.89. This amount multiplied by 200% yields a MAR of \$83.78.
- Procedure code 77003 is unbundled. This procedure is a component service of procedure code 64483 performed on the same date. Payment for this service is included in the payment for the primary procedure. A modifier is not allowed. Separate payment is not recommended.
- Procedure code 64483 has a status indicator of T, which denotes a significant procedure subject to multiple-procedure discounting. The highest paying status T procedure is paid at 100%; all others are paid at 50%. This procedure is paid at 100%. These services are classified under APC 0207, which, per OPPS Addendum A, has a payment rate of \$485.34. This amount multiplied by 60% yields an unadjusted labor-related amount of \$291.20. This amount multiplied by the annual wage index for this facility of 0.8883 yields an adjusted labor-related amount of \$258.67. The non-labor related portion is 40% of the APC rate or \$194.14. The sum of the labor and non-labor related amounts is \$452.81. Per Medicare Claims Processing Manual, CMS Publication 100-04, Chapter 4, §10.7.1, if a claim has more than one surgical service line with a status indicator of S or T and any of those lines has a charge of less than \$1.01, then the charges for all S and T lines are summed and the charges are divided across those lines in proportion to their APC payment rate. The new charge amount is used in place of the submitted charge amount in the line-item outlier calculation. This claim has a status indicator S or T line item with a billed charge less than \$1.01; therefore, all S and T line charges are reallocated accordingly. The APC payment for this service of \$679.22 divided by the sum of all S and T APC payments of \$1,156.81 gives an APC payment ratio for this line of 0.587147, multiplied by the sum of all S and T line charges of \$7,606.00, yields a new charge amount of \$4,465.84 for the purpose of outlier calculation. The provider billed this service with modifier 50. Bilateral procedures are paid at the rate for two units. The highest paying status indicator T procedure is paid at 100% for the first unit; each additional T procedure unit is paid at 50%. The APC amount is \$679.22. The cost of these services does not exceed the annual fixed-dollar threshold of \$2,175. The outlier payment amount is \$0. The total APC payment for this line is \$679.22. This amount multiplied by 200% yields a MAR of \$1,358.43.
- Procedure code 64493, date of service 08/2/10, has a status indicator of T, which denotes a significant procedure subject to multiple-procedure discounting. The highest paying status T procedure is paid at 100%; all others are paid at 50%. This procedure is paid at 50%. These services are classified under APC 0207, which, per OPPS Addendum A, has a payment rate of \$485.34. This amount multiplied by 60% yields an unadjusted labor-related amount of \$291.20. This amount multiplied by the annual wage index for this facility of 0.8883 yields an adjusted labor-related amount of \$258.67. The non-labor related portion is 40% of the APC rate or \$194.14. The sum of the labor and non-labor related amounts is \$452.81. Per Medicare Claims Processing Manual, CMS Publication 100-04, Chapter 4, §10.7.1, if a claim has more than one surgical service line with a status indicator of S or T and any of those lines has a charge of less than \$1.01, then the charges for all S and T lines are summed and the charges are divided across those lines in proportion to their APC payment rate. The new charge amount is used in place of the submitted charge amount in the line-item outlier calculation. This claim has a status indicator S or T line item with a billed charge less than \$1.01; therefore, all S and T line charges are reallocated accordingly. The APC payment for this service of \$452.81 divided by the sum of all S and T APC payments of \$1,156.81 gives an APC

payment ratio for this line of 0.391432, multiplied by the sum of all S and T line charges of \$7,606.00, yields a new charge amount of \$2,977.23 for the purpose of outlier calculation. The provider billed this service with modifier 50. Bilateral procedures are paid at the rate for two units. The highest paying status indicator T procedure is paid at 100% for the first unit; each additional T procedure unit is paid at 50%. The APC amount is \$452.81. The cost of these services does not exceed the annual fixed-dollar threshold of \$2,175. The outlier payment amount is \$0. The total APC payment for this line, including multiple-procedure discount, is \$452.81. This amount multiplied by 200% yields a MAR of \$905.62.

- Procedure code J1040 has a status indicator of N, which denotes packaged items and services with no separate APC payment; payment is packaged into the reimbursement for other services, including outliers.
 - Procedure code J2250 has a status indicator of N, which denotes packaged items and services with no separate APC payment; payment is packaged into the reimbursement for other services, including outliers.
 - Procedure code 93005, date of service July 30, 2010, has a status indicator of S, which denotes a significant procedure, not subject to multiple-procedure discounting, paid under OPPS with separate APC payment. These services are classified under APC 0099, which, per OPPS Addendum A, has a payment rate of \$26.56. This amount multiplied by 60% yields an unadjusted labor-related amount of \$15.94. This amount multiplied by the annual wage index for this facility of 0.8883 yields an adjusted labor-related amount of \$14.16. The non-labor related portion is 40% of the APC rate or \$10.62. The sum of the labor and non-labor related amounts is \$24.78. Per Medicare Claims Processing Manual, CMS Publication 100-04, Chapter 4, §10.7.1, if a claim has more than one surgical service line with a status indicator of S or T and any of those lines has a charge of less than \$1.01, then the charges for all S and T lines are summed and the charges are divided across those lines in proportion to their APC payment rate. The new charge amount is used in place of the submitted charge amount in the line-item outlier calculation. This claim has a status indicator S or T line item with a billed charge less than \$1.01; therefore, all S and T line charges are reallocated accordingly. The APC payment for this service of \$24.78 divided by the sum of all S and T APC payments of \$1,156.81 gives an APC payment ratio for this line of 0.021421, multiplied by the sum of all S and T line charges of \$7,606.00, yields a new charge amount of \$162.93 for the purpose of outlier calculation. The cost of these services does not exceed the annual fixed-dollar threshold of \$2,175. The outlier payment amount is \$0. The total APC payment for this line is \$24.78. This amount multiplied by 200% yields a MAR of \$49.56.
4. The total allowable reimbursement for the services in dispute is \$2,438.03. This amount less the amount previously paid by the insurance carrier of \$2,428.41 leaves an amount due to the requestor of \$9.62. This amount is recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is \$9.62.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby **ORDERS** the respondent to remit to the requestor the amount of \$9.62, plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this order.

Authorized Signature

Signature

Medical Fee Dispute Resolution Officer

April 8, 2013
Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for

a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party.**

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.